



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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April 5, 2007

Greg Maurer, Administrator  
Elmore Medical Center  
P.O. Box 1270  
Mountain Home, ID 83647

Provider #: 131311

Dear Mr. Maurer:

On **February 8, 2007**, a Complaint Investigation was conducted at Elmore Medical Center. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00002324**

**Allegation #1:** A patient signed a release of information form so that her daughter could access her records, but staff have been slow to respond to her request.

**Findings:** An unannounced visit was made to investigate the complaint. During the investigation, staff were interviewed and reviews were conducted of medical records and hospital policies.

Four closed records were reviewed. The record for one patient contained a form titled "Authorization for Release of Information" which was signed by the patient on 12/7/06.

A Health Information Management employee stated, on 2/8/07 at 12:05 PM, that she received the signed request on 12/7/06. She stated she copied the patient's record and delivered it to the patient in her hospital room that same day.

**Conclusion:** Unsubstantiated. Lack of sufficient evidence.

Record information was provided in a timely manner following signed patient authorization. No deficient practice was identified and no deficiencies were cited.

**Allegation #2:** Nursing staff did not put a patient's call light where she could reach it. One time she rang and they did not come for 15 minutes.

**Findings:** Unsubstantiated. Lack of sufficient evidence.

During the unannounced investigation, patients were interviewed and medical records were reviewed.

Four closed records were reviewed. Each record contained frequent nursing documentation related to call light placement.

Observations were made and three current patients, including one Swing-bed patient, were interviewed at 12:30 PM. Two of the three patients were out of bed, seated in chairs. The third was positioned on her side. Call lights were observed to be in reach for each of the patients. All three patients stated they were able to easily reach and use their call lights. They stated call lights were answered "within seconds" and "almost before you took your finger off of the button". They said nurses were responsive and care was "just great".

**Conclusion:** Unsubstantiated. Lack of sufficient evidence.

No nursing services issues were identified and no deficiencies were cited.

**Allegation #3:** A patient fell to her knees and tried to catch herself with her walker. She had bruises on her chest and under her arms, as well as a swollen toe that looked broken. Staff did not notify the patient's husband of the fall. No x-rays were taken and no treatment was provided.

**Findings:** During the unannounced investigation, reviews were conducted of medical records and incident reports.

In addition, the Director of Risk Management was interviewed.

Four closed records were reviewed. The record for one patient contained documentation related to a fall. Nursing documentation dated 11/29/06 at 5:40 PM, stated "Apparently while going to/from restroom patient went down to her knees with the help of CNA (Certified Nursing Assistant) (name) there was an accident report filled out. She did not fall but was assisted". Documentation indicated the patient complained of pain "all over" and told staff she could not move "at all". No documentation was found to indicate the patient told staff, at the time of the incident, that she hit her chest or arms when she was being lowered to the floor or that she had injured her toe. No documentation of a toe injury was noted until 11/30/06. The bruises on her chest and arms were first identified on 12/1/06.

The incident report, dated 11/29/06, stated "Pt. was walking back to chair from bathroom. Eased to floor on knees...c/o (complained of) knee pain which eased when legs straightened...Attempted to call husband no answer". The follow-up to the incident indicated the patient was examined by a registered nurse and the patient's physician. No injuries were noted at that time.

A physician's progress note, dated 11/29/06, stated "The patient apparently had an episode where she was walking to the bathroom, became weak, and slipped to the floor. The nurses described this as a very slow sitting down, there was no force associated with it. The patient subsequently complained of leg pain, arm pain, neck pain and that her tongue was swollen". The patient was examined and contractures in both knees were documented. Physician progress notes, dated 12/4/06, stated the patient was examined and she had "a bruise that is setting between her breasts". It further stated the bruising "had been evaluated previously and felt to be simple bruises and contusions" The physician stated he did "not believe she has fractured a rib or injured her foot significantly". The physician's discharge summary, dated 12/21/06, stated "During this stay the patient had a fall, which the nurses described as the patient slowly let herself down to the floor. The patient disagreed and described it as more violent. She states she injured her chest when she fell against the walker. She did develop bruises in her axilla and also on her sternum and she stated she injured her big toe on the right foot. It was examined and found to be inflamed and tender. It looked more infected than bruised. Therefore it was treated like a cellulitis. It appeared to be resolving with antibiotics".

The Director of Risk Management was interviewed on 2/8/07 at 12 PM. She stated patient falls were reported, investigated and tracked through the hospital's quality improvement process. A review of data related to falls revealed four patient falls were reported during the past six months, one of which was the "fall/assisted to floor" incident described previously. Investigations were documented for each occurrence and actions taken to prevent additional falls.

All of the documentation indicated an incident occurred on 11/29/06. The subsequent bruising indicated the patient most likely leaned on the walker for support as she was going down to her knees and the walker prevented the patient from falling to the floor. The contact with the walker resulted in bruising.

Documentation stated staff attempted to notify the patient's husband, but there was no answer at their residence. Further documentation indicated the patient's husband arrives shortly after the incident and may have been in route when staff made the call.

The patient was assessed by a registered nurse and her physician. No x-rays were ordered by the physician. Medication was ordered and given related to the swollen toe and improvement was documented.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

No patients' rights issues were identified and no deficiencies were cited.

**Allegation #4:** When the daughter asked staff about the fall, she was given minimal and conflicting information. She requested a meeting with the clinical director, but had a problem getting one scheduled. No one will give her a straight answer or tell her what happened when her mother fell.

Findings: During the investigation, medical records and incident reports and their subsequent investigations were reviewed.

The investigation and follow-up information related to one fall included documentation of a meeting on 12/5/06, four working days after the incident. Those present included the patient, her daughter, the Chief Nursing Officer (CNO) and the Clinical Director. The meeting included discussion of the patient's bruises. The Clinical Director and CNO stated an investigation would be conducted and the daughter would be notified of the results. An investigation was documented, including an account of the incident written by the Certified Nursing Assistant present at the time of the fall. The findings of the investigation were reported to the patient's daughter in a letter, dated 12/19/06, which was sent by certified mail.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

No patients' rights issues were identified and no deficiencies were cited.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



PENNY SALOW  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Supervisor  
Non-Long Term Care

PS/mlw

Enclosures